

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

The following ambulatory services are provided.

Rural health clinic services  
Other laboratory and x-ray services  
Early and Periodic Screening, Diagnosis, and Treatment  
Family planning services  
Physicians' services  
Podiatrists' services  
Optometrists' services  
Chiropractors' services  
Other practitioners' services  
Home health services  
Private duty nursing services  
Clinic services  
Dental services  
Physical therapy and related services  
Prescribed drugs, dentures, and prosthetic devices  
Eyeglasses  
Transportation  
Personal care services

*Nurse practitioners etc*

*2/8/91 phone  
Murray Staley - 9/7/71  
re: updating pg.*

\*Description provided on attachment.

TN No. MS-86-25  
Supersedes  
TN No. MS-81-11

Approval Date 1/07/87

Effective Date 10/1/86

HCFA ID: 0140P/0102A

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICE PROVIDED  
MEDICALLY NEEDY GROUP(S): All groups

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations\*

- 2.a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations\*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan).

☒ Provided: ☐ No limitations ☒ With limitations\*

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided: ☐ No limitations ☒ With limitations\*

3. Other laboratory and x-ray services.

☒ Provided: ☒ No limitations ☐ With limitations\*

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☒ With limitations\*

- b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

☒ Provided ☒ No limitations ☐ With limitations\*

- c. Family planning services and supplies for individuals of childbearing age

☒ Provided: ☒ No limitations ☐ With limitations\*

\*Description provided on attachment

TN NO. MS-92-1

APR 10 1992

NOV 01 1991

Supersedes Approval Date \_\_\_\_\_

Effective Date \_\_\_\_\_

TN NO. MS-91-24

HCFA ID: 7986E

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY  
GROUP(s): All groups

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided:      No limitations X With limitations\*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: X No limitations      With limitations:

\*Description provided on attachment.

TN No. MS-93-11  
Supersedes      Approval Date JUL 12 1993 Effective Date APR 01 1993  
TN No. MS-92-23

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All covered groups

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

☒ Provided: ☐ No limitations ☒ With limitations\*

b. Optometrists' Services

☒ Provided: ☐ No limitations ☒ With limitations\*

c. Chiropractors' Services

☒ Provided: ☒ No limitations ☐ With limitations\*

d. Other Practitioners' Services

☒ Provided: ☐ No limitations ☒ With limitations\*

7. Home Health Services

- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☐ With limitations\*

- b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations\*

- c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations\*

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☐ With limitations\*

\*Description provided on attachment.

TN No. MS-86-25  
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TN No. MS-81-11

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1/07/87

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State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All covered groups

8. Private duty nursing services.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

9. Clinic services.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

10. Dental services.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

11. Physical therapy and related services.

a. Physical therapy.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

b. Occupational therapy.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

b. Dentures.

~~XX~~ Provided: ☐ No limitations ☒ With limitations\*

\*Description provided on attachment.

TN No. MS-93-15

Supersedes

TN No. MS-90-14

Approval Date AN 26 1988

Effective Date NOV 17 1988

HCFA ID: 0140P/0102A

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All covered groups

c. Prosthetic devices.

X Provided:      No limitations X With limitations\*

d. Eyeglasses.

X Provided:      No limitations X With limitations\*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

     Provided:      No limitations      With limitations\*

b. Screening services.

X Provided:      No limitations X With limitations\*

c. Preventive services.

     Provided:      No limitations      With limitations\*

d. Rehabilitative services.

X Provided:      No limitations X With limitations\*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: X No limitations      With limitations\*

b. Skilled nursing facility services.

X Provided: X No limitations      With limitations\*

\*Description provided on attachment

Transmittal # MS-95-9

Supersedes

Approved FEB 20 1995

Effective APR 01 1995

Transmittal # MS-91-3

Substitute for Letter 86-000 1/18/95

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All covered groups

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations\*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations\*

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☐ No limitations ☒ With limitations\*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations\*

- ? 17. Nurse-midwife services.

*now mandatory*  
☐ Provided: ☐ No limitations ☐ With limitations\*  
Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations\*  
Not provided

\*Description provided on attachment.

TN No. MS-86-25  
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TN No. MS-81-11

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1/17/87

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10/1/86

HCFA ID: 0140P/0102A

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☒ Provided: ☒ With limitations\*

☐ Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

☐ Provided: ☐ With limitations\*

☒ Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

☒ Provided: <sup>+</sup> ☐ Additional coverage <sup>++</sup>

- b. Services for any other medical conditions that may complicate pregnancy.

☒ Provided: <sup>+</sup> ☐ Additional coverage <sup>++</sup> ☐ Not provided.

1. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☒ No limitations ☐ With limitations\*

☐ Not provided.

- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

State: Nebraska

Major Categories of Services That Are Available As  
Pregnancy-Related Services or Services For Any  
Other Condition That May Complicate Pregnancy

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The Nebraska Medical Assistance Program covers the following major categories of services as pregnancy-related services or services for a condition that may complicate pregnancy:

1. All services covered under the Title XIX Plan are available when pregnancy-related or for a condition that may complicate pregnancy; and
2. The same limitations listed in Attachment 3.1-A are applied to pregnancy-related services or services for a condition that may complicate pregnancy.

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All groups

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations\*

☒ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

- a. Transportation. *(Emergency only)*

☒ Provided: ☐ No limitations ☒ With limitations\*

- b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations\*

☒ Not Provided

- c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations\*

☒ Not provided

- d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations\*

- e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations\*

- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations\*

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